Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Tweed a prisoner at HMP Wakefield on 1 October 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Peter Tweed died on 1 October 2018 of lymphoma (a type of cancer) at HMP Wakefield. He was 60 years old. I offer my condolences to Mr Tweed's family and friends.

Mr Tweed had several long-term health conditions but was often uncooperative with his treatment and repeatedly refused blood tests. This made it difficult for staff to monitor his health. He was not diagnosed with lymphoma while he was alive.

I am satisfied that most of the care Mr Tweed received at Wakefield was of a good standard. However, the investigation found that the care he received in the final month of his life was not equivalent to that which he could have expected to receive in the community. A nurse failed to refer Mr Tweed for a GP appointment a few weeks before he died and failed to use a clinical tool to identify signs of deterioration, which would have been good practice.

On the day Mr Tweed died, there was a delay in staff calling a medical emergency code, which resulted in a short delay in an ambulance being called. The delay was unlikely to have affected the outcome for Mr Tweed, but this is an issue we have raised with Wakefield before.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **August 2019**

Contents

Summary

Events

1. In January 2006, Mr Peter Tweed was sentenced to life imprisonment for sexual offences. He was moved to HMP Wakefield in March 2006.

2. Mr Tweed had several long-term health conditions including high blood pressure and osteoporosis (a condition in which the bones become brittle and fragile). Healthcare staff created care plans and monitored his conditions frequently. Mr Tweed did not always act on the advice healthcare staff gave him, repeatedly declined blood tests and often refused to take his medication. Healthcare and prison staff encouraged him to engage.

3. On 6 September 2018, a nurse saw Mr Tweed for a review and he reported sporadic chest pain. She noted that he appeared to have lost weight and requested a GP review and a nurse's clinic appointment. On 10 September, a nurse noted that Mr Tweed had high blood pressure and a high resting heart rate. Mr Tweed asked to restart his medication and the nurse noted that she would request a GP review. However, there is no record that a GP saw Mr Tweed.

4. On 1 October, at 5.40pm, two officers found Mr Tweed sitting on his toilet with his head on his arms. Mr Tweed said he was okay and the officers left the cell. They returned a short time later and asked for a nurse to see him. The nurse noticed that he looked grey and had rapid breathing. She asked an officer to radio for a nurse to attend with an emergency bag. Control room staff asked for more information and subsequently called an ambulance.

5. Mr Tweed's condition deteriorated and at around 6pm, he went into cardiac arrest. Staff started cardiopulmonary resuscitation (CPR), which they continued until paramedics arrived and took over. At 6.25pm, a paramedic declared that Mr Tweed had died.

6. The post-mortem report shows that Mr Tweed died from malignant lymphoma (a type of cancer that starts in the lymphatic system).

Findings

7. The clinical reviewer found that although most of the care Mr Tweed received at Wakefield was of a good standard, the care he received in the final month of his last period in custody was not equivalent to that which he could have expected in the community.

8. We are concerned that Mr Tweed was not seen by a GP despite two nurses noting in September that he should have a GP review. The nurse who saw him on 10 September should also have considered assessing Mr Tweed under the National Early Warning Score (NEWS) system, which would have identified whether his health was deteriorating and whether he required clinical intervention or further monitoring.

9. Staff did not call a medical emergency code as they should have done, which caused a short delay in calling an ambulance. While the delay did not affect the

outcome for Mr Tweed, it is important that staff use the correct medical emergency procedures to ensure an ambulance is called immediately.

10. There was a delay in the prison notifying Mr Tweed's next of kin of his death.

Recommendations

- The Head of Healthcare should ensure that healthcare staff:
    - receive training to help detect and treat early warning signs of deterioration in prisoners with long-term health conditions; and
    - ensure that all requests for follow up medical appointments are acted upon promptly.
- The Governor and Head of Healthcare should that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of the emergency.
- The Governor should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death promptly, in line with national guidance.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

12. The investigator obtained copies of relevant extracts from Mr Tweed's prison and medical records.

13. The investigator interviewed two members of staff by telephone on 14 November 2018.

14. NHS England commissioned a clinical reviewer to review Mr Tweed's clinical care at the prison.

15. We informed HM Coroner for the County of West Yorkshire of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The investigator wrote to Mr Tweed's next of kin to explain the investigation and to ask if he had any matters he wanted the investigation to consider. We received no response.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Wakefield

18. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

19. Care UK have provided all healthcare provision at Wakefield since 1 April 2016. They provide primary healthcare services during normal working hours and overnight and weekend care in the inpatient unit for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wakefield was in June 2018. Inspectors found that clinical governance had improved since the last inspection and good prisoner consultation at a monthly patient forum influenced service improvement. They noted that access to healthcare services was good and staffing levels were reasonable to support primary care, although there had been some delays with social care assessments.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 April 2018, the IMB noted that the integration of separate nursing teams following the change of healthcare provider remained positive. It also noted that there had been a significant shift towards nursing staff working more collaboratively with hospital staff as a way of providing better, more integrated care for prisoners

Previous deaths at HMP Wakefield

22. Mr Tweed was the 19th prisoner to die at HMP Wakefield since October 2015. All the deaths were from natural causes. There have been two deaths since, one from natural causes and one awaiting classification. We have previously made recommendations about monitoring clinical deterioration in prisoners with chronic conditions and calling medical emergency codes.

Key Events

23. On 24 January 2006, Mr Peter Tweed was sentenced to life in prison for sexual offences and sent to HMP Peterborough. He was moved to HMP Wakefield on 10 March 2006.

24. Mr Tweed had several long-term health conditions including asthma, hypertension (high blood pressure) and lumbosacral spondylosis (degenerative changes in the lower spine). Healthcare staff created care plans, reviewed him frequently and prescribed appropriate medication. Records show that Mr Tweed often failed to attend appointments and was uncooperative about his treatment. He consistently refused to have blood tests taken, stating he had a needle phobia, and healthcare staff regularly spoke to him about the risks of an incomplete assessment.

25. On 6 June 2017, a prison GP saw Mr Tweed for a review and he reported chest pain, difficulty walking and numbness after standing for a prolonged period. He noted that Mr Tweed had abdominal tenderness and spinal stiffness and referred him for several tests, including a dual energy X-ray absorptiometry scan (DEXA – a special type of X-ray that measures bone mineral density).

26. On 21 September, a prison GP saw Mr Tweed to discuss the result of his DEXA scan, which showed osteoporosis (a condition in which the bones become brittle and fragile). He told Mr Tweed that blood tests were required to establish the underlying cause and explained the risks of proceeding without them. He discussed ways that Mr Tweed could manage his anxiety around needles, but Mr Tweed continued to decline a blood test. He prescribed naproxen (an anti-inflammatory medication) to treat back pain, and alendronic acid and colecalciferol (a mineral and vitamin D supplement) to strengthen bones. He noted that proceeding without conducting blood tests was less of a risk than leaving the condition untreated.

27. On 11 January 2018, a prison GP saw Mr Tweed to review his pain medication and he said that although naproxen helped to manage his pain, the effects wore off too quickly. He discussed blood tests with Mr Tweed, which he continued to decline, and prescribed buprenorphine (an opiate based pain relief medication) in the form of a skin patch, to provide 24-hour pain relief.

28. On 2 March, a nurse saw Mr Tweed for a review as he had not collected his buprenorphine patch for three weeks and she noticed that he still had the original one on his arm. He told her that the patch did not help his pain and she explained that he had to start on a lower dose and increase it gradually for it to work effectively. Mr Tweed reported difficulty walking down stairs and she suggested he move to a more accessible landing, but he refused. Records show that from this point, Mr Tweed refused to take his prescribed medication.

29. On 13 March, two nurses saw Mr Tweed for a review and suggested he move to a lower landing so officers could take him to appointments and to collect his medication by wheelchair. He said he had been in the same cell for 11 years and that his “head will go” if he was moved. A nurse asked if he would like to see a mental health nurse, but he declined, stating they were “rubbish”. Both nurses

encouraged Mr Tweed to engage and offered him a temporary move to the prison's inpatient unit to resolve his pain, but he refused.

30. On 16 April, a nurse attended a multidisciplinary team (MDT) meeting with healthcare and prison staff to discuss their ongoing concerns about Mr Tweed's non-compliance with medication and his reported difficulty walking. She recorded that mental health staff felt Mr Tweed was manipulating the situation to stay on the wing and that they had no concerns about his mental capacity to make decisions about his care. She also noted that Mr Tweed had a clean cell, good personal hygiene and that another prisoner collected his meals for him.

31. On 4 April, Mr Tweed submitted a complaint saying he felt intimidated and bullied into deciding to move landings and that he would refuse to engage if moved. On 24 April, a prison manager responded to Mr Tweed and explained that prison and healthcare staff were trying to take account of his needs and to keep him safe. She also reminded Mr Tweed that he had been invited to attend a recent MDT to share his views, but had refused to participate.

32. On 23 May, a prisoner supporting Mr Tweed with his care needs wrote to prison staff saying that he was withdrawing his voluntary support, as he only took on the role temporarily and was frustrated that staff had not formulated a plan for Mr Tweed. The next day, an officer responded to the prisoner saying that while he could not discuss Mr Tweed's care, prison and healthcare staff were aware of his needs.

33. Over the next three months, healthcare staff encouraged Mr Tweed to engage and explained the detrimental effect not taking his medication could have on his health. They monitored his food intake and suggested a prisoner carer could collect his meals, but he refused. An officer monitored Mr Tweed during regular keywork sessions, but he continued to decline a move to a lower landing despite recognising that he struggled to get down stairs. Records show that Mr Tweed could get around sufficiently to collect his own food and water.

34. On 5 September, Mr Tweed submitted a medical application stating that he had chest pain and had been using the toilet a lot. The next day, a nurse saw him on the wing and he reported that he had had sporadic chest pain for several weeks. She noted that he required a GP appointment to discuss restarting his medication as well as a nurse's clinic appointment, as he appeared to have lost weight. However, there is no record that a medication review with a GP was requested.

35. On 10 September, a nurse saw Mr Tweed for a clinic appointment and completed a Malnutrition Universal Screening Tool (MUST – a scoring system to identify adults who are malnourished, at risk of malnourishment, or obese). He scored '1' (medium clinical risk) and the nurse suggested a review in four weeks. She recorded a high blood pressure reading of 133/75 mmHg (normal being between below 120/40 mmHg) and a high resting heart rate of 103bpm (normal being 60-100bpm). She also noted that Mr Tweed wanted to restart his medication and that she would request a GP appointment. However, there is no record that she booked a GP review or considered a National Early Warning Score assessment (NEWS – a scoring system to assess clinical deterioration in patients.).

Events on Monday 1 October

36. At 5.40pm, while conducting cell checks, two officers saw Mr Tweed sitting on his toilet behind a privacy screen, with his head on his arms. An officer entered the cell to check on Mr Tweed who said he was okay. The officers left the cell, but returned a short time later and asked a nurse, who was on the wing issuing flu jabs, to see him.

37. The nurse went to Mr Tweed's cell and saw him sitting on his toilet looking grey and breathing rapidly. She told the investigator that she asked an officer to request an ambulance as she had only gone into work to issue flu jabs and did not have a radio. The officer told us that the nurse asked him to request that a nurse attend with an emergency bag. Records show that the officer requested a nurse attend at 5.51pm, and that the nurse used his radio to ask the other nurse to bring an emergency bag. Mr Tweed reported chest pain and the nurse helped officers move him onto his bed. The other nurse arrived with an emergency bag, could not obtain Mr Tweed's pulse rate or oxygen saturation level due to his poor circulation, and issued him 15 litres of oxygen via a mask.

38. At 5.53pm, control room staff called an ambulance after establishing from an officer that the situation was a medical emergency code blue (used to indicate that a prisoner is unconscious or having breathing difficulties). Additional healthcare staff arrived and Mr Tweed's condition quickly deteriorated. A nurse attached defibrillator pads to his chest, and at around 6pm, he went into cardiac arrest. An advanced nurse practitioner, started cardiopulmonary resuscitation (CPR) and the defibrillator advised no shock. Minutes later, paramedics arrived and took over resuscitation. At 6.25pm, a paramedic declared that Mr Tweed had died.

Contact with Mr Tweed's family

39. At 8.38pm, a prison manager phoned the duty family liaison officer (FLO), and informed him of Mr Tweed's death. The following day, at 9.45am, an officer took over as FLO and established that Mr Tweed had named a friend, who lived 133 miles away, as his next of kin. The FLO contacted the closest prison to Mr Tweed's next of kin's address, HMP Littlehey, and arranged for a FLO, to break the news of Mr Tweed's death. At around 4pm, the FLO told Mr Tweed's next of kin that he had died and provided the contact details of the FLO from HMP Wakefield.

40. The FLO provided ongoing support to Mr Tweed's next of kin. He also contacted Mr Tweed's daughter, who said she was happy for Mr Tweed's friend to act as the next of kin. The FLO maintained regular contact with Mr Tweed's family and friends and arranged his funeral, which he attended with a prison manager on 13 November. The prison contributed toward the cost in line with national policy.

Support for prisoners and staff

41. After Mr Tweed's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

42. The prison posted notices informing other prisoners of Mr Tweed's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Tweed's death.

Post-mortem report

43. The post-mortem report found that Mr Tweed died of malignant lymphoma (a type of cancer that starts in the lymphatic system), which had spread widely throughout his body.

Events after Mr Tweed's death

44. On 9 October, a prisoner who had been supporting Mr Tweed on the wing wrote to the investigator and wanted to know:

- who prescribed Mr Tweed naproxen and why;
- the reason Mr Tweed stopped receiving medication; and
- why the prison did not provide alternative support for Mr Tweed when he withdrew his voluntary assistance.

Findings

Clinical care

45. Mr Tweed had several long-term conditions but did not always engage with treatment. Healthcare staff reviewed him frequently, created care plans and prescribed appropriate medication. The clinical reviewer considered that staff attempted to manage Mr Tweed's health conditions in line with national guidance, but his refusal to engage made it difficult to provide effective care. Staff worked hard to adapt Mr Tweed's care to meet his needs and preferences and explored several options with him. They regularly encouraged Mr Tweed to have a blood test, explored his anxiety around needles and clearly explained the risks of not having a blood test.

46. The clinical reviewer noted that when Mr Tweed refused to take his medication between 2 March and 10 September, healthcare staff explained the detrimental effect this could have on his health. The clinical reviewer concluded that staff could not have predicted or prevented Mr Tweed's death and that they had made every effort to engage him.

47. The clinical reviewer considered that most of the care Mr Tweed received at Wakefield was of a good standard. However, there was one aspect of Mr Tweeds care that fell short of the care he could have expected in the community. We are concerned that healthcare staff did not book a GP appointment or record a NEWS score on 10 September. The clinical reviewer considered that if staff had recorded a NEWS score, Mr Tweed would have scored '3', indicating that clinical monitoring should have continued. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff:

    - **receive training to help detect and treat early warning signs of deterioration in prisoners with long-term health conditions; and**
    - **ensure that all requests for follow up medical appointments are acted upon promptly.**

Emergency response

48. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Wakefield's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.

49. An officer called for healthcare assistance over the radio, not a code blue. This meant that the control room did not call an ambulance straightaway and had to check whether the situation was a medical emergency before doing so, causing a two minute delay. Although the delay was unlikely to have changed the outcome for Mr Tweed, in other circumstances, any delay could be crucial.

50. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency.

51. The clinical reviewer considered that healthcare staff responded promptly to the emergency and took appropriate medical action, in line with national guidelines.

Informing Mr Tweed's next of kin

52. Prison Rule 22 states that if a prisoner dies or becomes seriously ill then the governor should inform the family at once. Prison Service Instruction (PSI) 64/2011 says that wherever possible, the family liaison officer and another member of staff should visit the next of kin or nominated person to break the news of the death. It notes that time will be of the essence in order to try to ensure that the family do not find out about the death from another source. If the next of kin live a long distance away, consideration must be given to requesting the assistance of a family liaison officer from the nearest prison.

53. Mr Tweed died at 6.25pm on 1 October, but his next of kin was not told until 4pm the next day. An officer, who was contacted at 8.38pm on 1 October as the duty FLO, told the investigator that due to the time of night, a prison manager advised him not to come into the prison. A prison manager told us that he could not find a record of Mr Tweed's next of kin and was under the impression that an officer had come into the prison to carry out the FLO role. It was not until the next morning that an officer, who took over as FLO, attended the prison and obtained the next of kin details. He then arranged for a FLO from HMP Littlehey to visit Mr Tweed's nominated next of kin.

54. While we recognise the prison appropriately arranged for a member of staff from HMP Littlehey to break the news to Mr Tweed's next of kin, we are concerned staff did not act more swiftly. We consider that staff should have identified Mr Tweed's next of kin on 1 October and arranged a visit to break the news that evening. We make the following recommendation:

The Governor should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death promptly, in line with national guidance.

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